Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
Church Mutual Insurance Co.

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-10-4461-01

MFDR Date Received
June 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been reimbursed; however, it was not processed according to the Acute Care Hospital Fee Guidelines set forth by the TWCC. Please review this information and reprocess this claim."

Amount in Dispute: $8,314.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The reconsideration EOB fully explains the payment for the date of service 6/23/09. On the medical bill sent to the Carrier (please see attached), there was not a billed amount for the CPT codes 29888 and 29866. The "total charges" column was left blank for each of these codes. Therefore, if no amount was charged, then no amount is owed."

Response Submitted by: Downs & Stanford, P.C. 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 23 to June 26, 2009	Outpatient Hospital Services	$8,314.38	$7,025.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 17, 2009
   - 97 Charge included in another Charge or Service
   - B15 Procedure/service is not paid separately
   - GP Service delivered under OP PT care plan
   - R95 Procedure Billing Restricted/See Medicare LCD
   - RN Not paid under OPPS: services included in APC rate
   - RT Right Side
   - TC Technical Component
   - W1 Workers' Compensation State Fee Schedule Adj

   Explanation of benefits dated November 12, 2009
   - 352 Network disc not applicable to procedure billed
   - 97 Charge Included in another Charge or Service
   - B15 Procedure/Service is not paid separately
   - GP Service delivered under OP PT care plan
   - RN Not paid under OPPS: services included in APC rate
   - RT Right Side
   - W4 No additional payment allowed after review
   - TC Technical Component

   Explanation of benefits dated January 6, 2010
   - 352 Network disc not applicable to procedure billed
   - 97 Charge Included in another Charge or Service
   - B15 Procedure/Service is not paid separately
   - GP Service delivered under OP PT care plan
   - ORC See Additional information
   - RT Right Side
   - W4 No additional payment allowed after review
   - TC Technical Component

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Did the respondent support the insurance carrier's reasons for denial of procedure codes 29888 and 9866?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services applicable to CorCare Network, Contract 05-0001791. Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the dates of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The respondent's position statement argues that "On the medical bill sent to the Carrier . . . there was not a billed amount for the CPT codes 29888 and 29866. The 'total charges' column was left blank for each of these codes. Therefore, if no amount was charged, then no amount is owed." Per 28 Texas Administrative Code §§ 134.403(e) and (e)(2), in the absence of a contracted fee, reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) "regardless of billed amount." 28 Texas Administrative Code §134.403(d) requires that "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided." Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §180.2 states that "When multiple surgical procedures are performed at the same session, it is not necessary

to bill separate charges for each procedure. It is acceptable to bill a single charge under the revenue code that describes where the procedure was performed (e.g., operating room, treatment room, etc.) on the same line as one of the surgical procedure CPT/HCPCS codes and bill the other procedures using the appropriate CPT/HCPCS code and the same revenue code, but with '0' charges in the charge field." Review of the submitted medical bill finds that the health care provider has met the billing requirements of §134.403(d). Moreover, 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, applicable to disputes filed on or after May 25, 2008, requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that, prior to the date the request for MDR was filed, the insurance carrier denied disputed services based on the reason that the health care provider failed to enter a charge amount in a required field or that the bill was incomplete. The Division concludes that the respondent has not met the requirements of §133.307(d)(2)(B); consequently, these newly raised defenses or denial reasons shall not be considered. The respondent's denial reasons are not supported. Reimbursement will therefore be calculated according to applicable Division rules and fee guidelines.

3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1713, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 36415, date of service June 23, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
   - Procedure code 80048, date of service June 23, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.36. 125% of this amount is $15.45. The recommended payment is $15.45.
   - Procedure code 85025, date of service June 23, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.35. 125% of this amount is $14.19. The recommended payment is

$14.19.

- Procedure code 73560, date of service June 26, 2009, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.82. This amount multiplied by the annual wage index for this facility of 0.8965 yields an adjusted labor-related amount of $24.04. The non-labor related portion is 40% of the APC rate or $17.88. The sum of the labor and non-labor related amounts is $41.92. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $41.92. This amount multiplied by 200% yields a MAR of $83.84.
- Procedure code 76000, date of service June 26, 2009, has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 29866 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
- Procedure code 29881, date of service June 26, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,165.87. This amount multiplied by the annual wage index for this facility of 0.8965 yields an adjusted labor-related amount of $1,045.20. The non-labor related portion is 40% of the APC rate or $777.25. The sum of the labor and non-labor related amounts is $1,822.45. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $911.23 divided by the sum of all S and T APC payments of $5,485.06 gives an APC payment ratio for this line of 0.166129, multiplied by the sum of all S and T line charges of $13,996.50, yields a new charge amount of $2,325.22 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line, including multiple-procedure discount, is $911.23. This amount multiplied by 200% yields a MAR of $1,822.46.
- Procedure code 29888, date of service June 26, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.8965 yields an adjusted labor-related amount of $1,748.78. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,049.22. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $3,049.22 divided by the sum of all S and T APC payments of $5,485.06 gives an APC payment ratio for this line of 0.555914, multiplied by the sum of all S and T line charges of $13,996.50, yields a new charge amount of $7,780.85 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.311. This ratio multiplied by the billed charge of $7,780.85 yields a cost of $2,419.84. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,049.22 divided by the sum of all APC payments is 54.38%. The sum of all packaged costs is $1,726.86. The allocated portion of packaged costs is $939.06. This amount added to the service cost yields a total cost of $3,358.90. The

cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $3,049.22. This amount multiplied by 200% yields a MAR of $6,098.44.

- Procedure code 29866, date of service June 26, 2009, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,251.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,950.67. This amount multiplied by the annual wage index for this facility of 0.8965 yields an adjusted labor-related amount of $1,748.78. The non-labor related portion is 40% of the APC rate or $1,300.44. The sum of the labor and non-labor related amounts is $3,049.22. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,524.61 divided by the sum of all S and T APC payments of $5,485.06 gives an APC payment ratio for this line of 0.277957, multiplied by the sum of all S and T line charges of $13,996.50, yields a new charge amount of $3,890.43 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line, including multiple-procedure discount, is $1,524.61. This amount multiplied by 200% yields a MAR of $3,049.22.
- Procedure code J0170, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0330, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1100, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service June 26, 2009, has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 0768, which, per OPPS Addendum A, has a payment rate of $0.20. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.12. This amount multiplied by the annual wage index for this facility of 0.8965 yields an adjusted labor-related amount of $0.11. The non-labor related portion is 40% of the APC rate or $0.08. The sum of the labor and non-labor related amounts is $0.19 multiplied by 12 units is $2.28. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total APC payment for this line is $2.28. This amount multiplied by 200% yields a MAR of $4.56.
- Procedure code J2250, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2710, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J3010, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120, date of service June 26, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

The total allowable reimbursement for the services in dispute is $11,091.91. This amount less the amount previously paid by the insurance carrier of $4,066.21 leaves an amount due to the requestor of $7,025.70. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,025.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,025.70, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 8, 2013
Signature	Medical Fee Dispute Resolution Officer	Date
		March 8, 2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.